specialists bulletin

A newsletter for our Specialists and General Practitioners

WINTER 2010

Issued by the Medical Director's Office

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Message from the CEO

"No harm"

St Vincents & Mercy Private Strategic Direction

Harm caused by hospital care and treatment is devastating to patients, families and health care providers. It has been widely accepted for the past decade that about one in ten Australian patients will have something go wrong during a hospital visit and as many as 18,000 patients die in Australian hospitals each year as a result of medical/ hospital error.[1] Such staggering figures are not only apparent in Australia but are also evident in overseas research. In the United States it has been estimated that between 44,000 and 98,000 Americans die each year as a result of medical errors.[2]

It is recognised that leadership is a critical element in implementing a successful patient safety program. Senior leaders are best placed to drive efforts in their health care organisations that foster the culture and commitment required to deal with underlying systemic causes of errors and harm to patients. St Vincents & Mercy Private has incorporated into its strategic plan for 2010-2012 focus on "No Harm" to reduce incidents of clinical harm and this has been endorsed by the hospital Board.

The hospital has been successful in the last several years in establishing a culture of incident reporting. This system of detecting error has relied upon voluntary reporting and research has shown that in general only 10 to 20 percent of errors are ever reported. It is recognised that the hospital needs a more effective way to identify events that do cause harm to patients in order to implement relevant changes to combat the occurrence of adverse events and outcomes. A best practice tool and methodology developed by the Institute for Healthcare Improvement (IHI)[3] has been implemented to measure the prevalence of harm within the organisation.

To establish the "No Harm" campaign a retrospective audit using the IHI methodology has recently been completed. The audit included a random collection of 240 patient medical records for the January 2009 - December 2009 period. The audit results indicated a 12.5% prevalence of harm[4] , which is comparable with peer organisations. The IHI audit will continue on a fortnightly basis throughout 2010- 2012, with measurements and targets being reported to all departments, Executive and Board on an ongoing basis. The hospital aims to cut its harm rate to 6% by 2013.

It is recognised that the IHI tool itself will do nothing to reduce the harm rate: It will require investment in interventions which reduce the causes of adverse events and patient harm that are identified using the IHI methodology. Such interventions will include amongst others:

- Reinforcement and consolidation of the "Ruby Red" Socks Falls Prevention Program
- Prevention of pressure ulcers by reliably using science-based guidelines for prevention of this serious and common complication
- Reinforcement of the requirement to follow the WHO surgical checklist and implementation of "Time Out" principles
- Continued participation in the National Hand Hygiene initiative
- Prevention of Methicillin-Resistant Staphylococcus Aureus (MRSA) infection by reliably implementing scientifically proven infection control practices throughout the hospital.
- Reinforcement of use of the ISBAR communication tool to ensure that the first sign of patient clinical decline is communicated accurately and effectively to avoid a catastrophic event.

The "No Harm" initiative at St Vincents & Mercy Private is consistent with the 'strong national standards and clear accountability for performance' objectives contained in the federal government's health reform agenda, "A National Health and Hospitals Network for Australia's Future-Delivering Better Health and Better Hospitals." By implementing this initiative at an early stage, St Vincents & Mercy Private will be a pace setter in Australia for improving health care standards.

In such a complex health care environment it is acknowledged that errors will occur. The key is to design a care delivery system so that harm does not reach the patient. Strategically, it is imperative that St Vincents & Mercy Private embeds and advances its culture of patient safety and, in doing so, improves the lives of the patients and communities they serve. ■

1. *Australian Institute of Health and Welfare (AIHW) 2009 "Towards national indicators of safety and quality in health care."*
2. *Kohn Lt, Corrigan JM, Donaldson MS. 1999. Committee on Quality of Health Care in America, Institute of Medicine. To Err is Human: Building a Safer Health System. Washington.*
3. *Institute for Healthcare Improvement. 2006. The Breakthrough Series: IHI Collaborative Model for Achieving Breakthrough Improvement*
4. *Institute for Healthcare Improvement defines harm as the "[u]nintended physical injury resulting from or contributed to by medical care, that requires additional monitoring, treatment or hospitalization, or that results in death. Such injury is considered harm whether or not it is considered preventable, whether or not it resulted from a medical error, and whether or not it occurred within a hospital. Category F: Temporary harm, initial or prolonged hospitalisation; Category G: Permanent patient harm; Category H: Intervention required to sustain life; Category I: Patient death.*

Electrophysiology New Service to Cardiology at St Vincents Private Hospital

St Vincents Private Hospital recently introduced Electrophysiology (EP) to complement the range of cardiac diagnostic and interventional procedures.

The provision of EP service on campus is seen as a strategic step to complement the existing comprehensive services in this specialty and to provide a one stop shop for the management of cardiovascular diseases.

The service is currently offered by Dr Uwais Mohamed in the cardiac catheter laboratory at St Vincents Private Hospital.

Staff News

Tribute to John J. Clarebrough

John Clarebrough graduated with First Class Honours from the Faculty of Medicine, University of Melbourne in 1947. Following Resident Medical Officer training at St Vincents Hospital he undertook training in cardiothoracic surgery at St Vincent's and Austin Hospitals and subsequently in London at the Brompton and Hammersmith Hospitals. In 1955 he was appointed Thoracic Surgeon to St Vincents Hospital subsequently became Cardiothoracic Surgeon when, following a period of research and training in open heart surgery in an animal laboratory at St Vincents Hospital, he performed the first open heart surgical procedure in patients during 1964.

In the first year of cardiac open heart surgery, only severely cardiac disabled patients could be operated on and as a consequence, their recovery was slow and closely monitored by both surgeons and cardiologists. Facilities were limited and consisted of monitoring equipment and DC counter shock equipment supplied through the University of Melbourne, Department of Medicine.

The results of surgery were such as to attract increasing numbers of patients to the unit and the results clearly impressed the Hospital and Charities Commission (State Department of Health) to grant St Vincent's Hospital with the University of Melbourne Teaching Hospitals Open Heart Surgical Unit, serving the needs of patients from both Royal Melbourne Hospital and Austin Hospital as well as St Vincents Hospital, all under the direction of John Clarebrough. Owing to his surgical and organisational skill the results of this combined unit continued to deliver excellent results. By April 1990 10,000 open heart procedures had been performed since 1964. Following the introduction of coronary bypass graft surgery in 1971 the workload increased and it was necessary for an Open Heart Surgical Unit to be opened at Royal Melbourne Hospital in 1980 and subsequently also at the Austin Hospital. At both hospitals the excellent results of open heart surgery achieved while at St Vincent's Hospital continued, to the benefit of all patients requiring heart surgery from Victoria and beyond.

John Clarebrough was also instrumental in the establishment of open heart surgery at St Vincent's Private Hospital and saw its introduction there again, with his hallmark clinical and organisational skills. He retired from surgery at both hospitals in 1988 and then held the post of Medical Director at St Vincents Private Hospital from 1988 to 1994.

Not only was John Clarebrough a skilled surgeon, he was also a consummate Cardiac Physician able to instill confidence into all members of the surgical team. He was ably supported by anaesthetists and trainee surgeons in the years before beginning cardiac surgery in the animal laboratory ensuring that there was a complete, fail-safe operational procedure for managing the cardio pulmonary bypass equipment even though it was extensively modified in the decade following the beginning of cardiac surgery. The same painstaking technical and teamwork approach enabled him to direct the beginning of open heart cardiac surgery at St Vincent's Private Hospital up to the time of his retirement from active surgery in 1988. During this period he was ably assisted by Mark O'Brien who directed cardiac surgery in Queensland through Prince Charles Hospital where Mark developed the use of tissue valve prostheses work that had begun with John Clarebrough at St Vincent's Hospital. Other cardiac surgeons ably mentored by John Clarebrough included John Richardson, Tony Wilson, Charles Mullany.

His clear thinking and "barefoot" legal skills led to many appointments and duties both in St Vincents Hospital and beyond e.g. establishing the Constitution of the Senior Medical Staff at St Vincent's Hospital while he was made President of the Cardiac Society of Australia and New Zealand (1978–1979), President of the Royal Australasian College of Surgeons (1981-1982), Vice President of the National Heart Foundation of Australia and was Chair of its Medical Scientific and Advisory Committee. In addition he was a member of or assistant to the Medical Practitioners Board of Victoria for 25 years and acted as an Adviser to State Government Health Departments. In this capacity he influenced the establishment of the highly successful Heart Transplant Unit at the Alfred Hospital.

John Clarebrough suffered an episode of poliomyelitis in 1961 (his second) and this led to temporary absence from surgical work. Nevertheless residual right arm weakness persisted throughout his surgical career but it was not obvious judging from his ability to sustain great physical effort for long periods of time in the operating room. Throughout his professional life he displayed not only enormous levels of skill and leadership but also great humility, qualities that led to the award of an OBE in 1975 and an AM in 1992. ■

Dr George Hale

From the Medial Director

Meropenem prescribing

I'd like to draw VMP's attention to the issue of antibiotic prescribing in general and that of meropenem in particular. Increasing focus is being placed on antibiotic prescribing at present with the imminent release by the NHMRC of the latest antibiotic guidelines and by The Australian Commission on Safety and Quality in Health Care of "Antibiotic Stewardship in Australian Hospitals". The latter program is already being implemented in a number of public teaching hospitals and will then spread into the private sector. Antibiotic stewardship programs will become an ACHS hospital accreditation issue in the coming few years. I am sure you will have all noted the recent outbreaks of antibiotic-resistant Clostridium difficile infection at Epworth and other hospitals. The development of this organism is thought to be directly linked to poor use of antibiotics particularly quinolones such as ciprofloxacin.

This brings me to meropenem. As you know, meropenem is a potent broad spectrum antibiotic that is active against many gram-positive and negative organisms including Pseudomonas and the Enterobactericeae. There is great concern amongst the infectious disease community that its use is currently excessive and is increasing the risk that resistance to this important agent will develop. The use of agents such as meropenem is certainly one of the areas of attention that any antibiotic stewardship program will address. Meropenem should only be used as a second or third line agent and in specific circumstances. It should not be prescribed generally. From a cost perspective, over $120,000 worth of meropenem has been prescribed at this Hospital in the last 10 months. Many of you may not be aware that meropenem is not on the Pharmaceutical Benefits Scheme which means that the Hospital is not funded in any way for its use. ■

Blood transfusions and PCA's = Two cannulae

Australian Red Cross standards state that blood and blood products may only be run in conjunction with normal saline. Therefore, another cannula must be inserted if a patient requires blood as well as other agents such as analgesia or antibiotics.

Sharp injuries

Needlestick injuries to surgeons or assistants in theatre continue to occur with distressing regularity. Some of these incidents are due to incorrect "handing back" of sharps after use. The correct procedure is described in the Commonwealth Infection Control Guidelines (http://www.health.gov.au/internet/main/publishing.nsf/Content/icg-guidelines-index.htm):
"Sharp instruments (see also Section 6.2) should not be passed by hand. A specified puncture-resistant sharps tray must be used for the transfer of all sharp instruments. Only one sharp must be in the tray at any time. If two surgeons are operating simultaneously (eg a varicose veins operation on both legs), each surgeon needs their own sharps tray."
This is also Hospital and RACS policy and must be adhered from now on by all surgeons. We would be failing in our responsibilities to you by not following best practice.

I would urge all VMP's that suffer a needle prick to immediately report it and be properly assessed including having blood taken as described in the above guidelines. ■

Accessing the ICU Registrar

ICU is asked from time to time to asses patients who are unwell on the wards. We are happy to offer this as a professional courtesy to our colleague especially over night.

There has been a trend recently for VMPS to direct ward nurses or the nursing supervisor to "get ICU" to sort out a variety of issues overnight. This is not appropriate. If needed a code blue should be called by the ward staff and ICU will attend in the usual manner. If medical assessment of a new of escalating problem is needed the VMP must ring and speak to the ICU registrar to:

1. Ascertain is it is clinically feasible for the ICU Reg to leave the ICU. If they are not able to leave the VMP will have to conduct the assessment.
2. Hand over the patient and the problem to the ICU Reg and ask them to undertake a specific evaluation, which will then be reported back to the VMP.

It is important to remember the VMP holds the clinical and the medico legal responsibility for this episode.

To streamline this process, a dedicated mobile phone number to contact the ICU Reg day and night is now available. The ICU Registrar's mobile number is 0408 169 853. ■

New National Registration Act

The National Registration of Health Professionals Act became law on July 1st. The aims of the Act are to streamline registration procedures for, initially, 10 health professions across Australia and to protect the public from health professionals whose practice has become unsafe. A new body has been constituted, the Australian Health Professionals Registration Authority (AHPRA), to handle the registration process. The various state Boards have become amalgamated into national boards such as the Medical Board of Australia. The new Act introduces for the first time in Victoria the issue of mandatory reporting of practitioners who engage in "notifiable conduct. This is where a registered health practitioner:

- practices while intoxicated by alcohol or drugs;
- engages in sexual misconduct in connection with practice;
- places the public at risk of substantial harm in his or her practice because of impairment;
- places the public at risk of harm in his or her practice in a way that constitutes a significant departure from accepted professional standard.

If you are a registered health practitioner you must report if you believe that another registered health practitioner has behaved in a way that constitutes notifiable conduct. If you fail to make a report, you may be liable to being investigated yourself for professional misconduct.

It is worth going to AHPRA's website (www.ahpra.gov.au) and familiarising yourself with the various aspects of the new registration model.

Attendance and note keeping

Recently, we have had a complaint from a patient's family regarding the lack of postoperative visits by a VMP to their relative. We are still investigating this complaint but it raised two general issues. First, the Hospital expects that VMP's, in particular the primary VMP, to visit patients regularly. In my view, this means daily. In the new by-laws, we have clarified the existing provision about visit frequency to mean daily. Secondly, the general standard of medical notes in this Hospital, like many others, leaves much to be desired. In this particular case, there is nothing in the history that would indicate that the VMP has been around. Whilst proof of attendance is not the main reason for making a progress note, it is a good one.

Workplace

What's new in our Maternity Care Centre?

The virtual baby visit has arrived!

Maternity patients at St Vincents Private Hospital can now send live streaming video of their new born babies hours after birth direct from their maternity cots to friends and family locally, interstate, and all around the world.

The trial of the Look@MyBaby service at St Vincents Private Hospital was widely reported across the country by Channel 7 News in May, and now St Vincents Private maternity rooms are fully equipped to make the service available to all new parents.

Look@MyBaby is an Australian developed solution which gives parents the ability to invite their friends and family via an ordinary text message to enjoy a 'Virtual Baby Visit' from their mobile phones and computers wherever they may be at the time.

"The solution is proving to be a wonderful value-adding service for our mothers," said Carol Canny, Acting Maternity Nurse Unit Manager. "It is not only ideal for mothers to allow distant friends and family to be introduced to their newborns in a much more meaningful way than just photos, but the Virtual Baby Visit also affords new parents the benefit of less interruption and possible infections from actual local visitors, plus greater time to themselves in hospital to recover," she added.

As many friends and family can meet the new baby as their parents invite. There is a once only charge of only $100 (ex GST) for the entire stay in hospital.

It is the same cost of a bunch of flowers and creates memories for a lifetime. Access to the Look@MyBaby service is secure. Parents choose their own password and are solely responsible for its distribution. Parents register for the Look@MyBaby service online via the St Vincents & Mercy Private homepage, www.stvincentsmercy.com.au or wwwlookatmybaby.net

Online Bookings for Antenatal Classes

Child Birth Education has introduced an innovative online booking system. It offers greater diversity in the way parents to be can book a tour within the hospital to view our Antenatal, Birth Suite and Postnatal Wards. Clients can access this through the hospital's web site, www.stvincentsmercy.com.au, then go into the Maternity Centre link to book from a range of tours offered on line. Parents may still ring the Maternity Bookings Centre on 9411 7444 to book a tour in person if they choose. The response from clients booking on line has been pleasing. About one third of clients booking tours are doing so online. The online booking system also generates an instant confirmation notification via email, and a reminder letter, if requested by the parent, closer to the tour date with relevant details about the tour and meeting location.

Breast Feeding Workshop

This is a specialist workshop offered by the hospital for women who wish to learn more about breastfeeding. The aim of the session is to compliment the knowledge gained by mothers at antenatal classes, provide up to date information in preparation for breastfeeding in the days, weeks and months after their baby's birth. Topics covered will include how breastfeeding works, establishing breastfeeding and the first feed, positioning and attachment, understanding milk supply and what is normal for a breastfeeding baby. The workshop will run twice each month on a Monday morning from 10.00AM-12.00 Midday effective 1st November 2010.

Partners in Early Parenting

Inspired by the ministry of Blessed Mary Mackillop, the Maternity Care Centre at St Vincents Private Hospital is launching a new program "Partners in Early Parenting" designed to provide early parenting support and advice for families with babies born at the hospital.

"Early parenting can be very challenging and overwhelming particularly in the first four months" said Ms Megan Burgmann, Midwife and Nurse Unit Manager of the Birth Suite at St Vincents Private. "We understand the pressure that families can experience after going home with a newborn, and we made the commitment to provide a helping hand beyond the hospital's walls" added Ms Burgmann.

Topics such as babies' sleeping patterns, breast and bottle feeding are covered during these meetings to develop parents' confidence so they can enjoy the adventure of parenting.

The program is offered to St Vincents Private Hospital families at no additional cost. Weekly meetings are held at the Mackillop room, Mary of the Cross Centre, Brunswick St, Fitzroy (adjacent to St Vincents Private). For more information please phone the Maternity Care Centre on (03) 9411 7400 or visit www.stvincentsmercy.com.au ■

We CARE

Continuum of care service

St Vincents & Mercy Private has a well established Continuum of Care Service which aims to provide a patient focused approach to streamlining a patient's admission from the time of presentation to a Consultant's room to their discharge from the hospital.

Continuum of Care Manager:
Angela Honeysett – 9928 6832

There are two areas within the Continuum of Care Department – Preadmission Services and Discharge Coordination Services

Pre-admission Services Manager:
Chris McShane – 9411 7398

The objective of the Preadmission is to ensure that patients are prepared for surgery prior to their arrival to hospital.

We have recently reviewed our processes and introduced new Patient Information Booklets as well as new Registration Forms.

We have received great feedback from individual Specialists as well as their Rooms regarding the forms and are happy to accommodate changes where we can. We review the forms fully before each re-print.

We have some exciting plans for the future of Preadmission. Already there are some Anaesthetist driven face to face Pre-admission Clinics for a number of Surgeons. We are looking to expand these in the forthcoming months.

If a patient attends these clinics we will ensure that pathology and radiology tests are done, and reported results are reviewed and forwarded to the treating specialists before admission where appropriate.

We have secured new premises on the St Vincents site and also continue to run Orthopaedic Classes at Mercy and a clinic at Vimy. If you are interested in participating in these or referring you patients to these clinics please have your Rooms contact us.

We are also focused on working with your Rooms to develop streamlined processes for referring patients to Preadmission.

We are keen to receive paperwork on patients as early as possible and encourage patients to complete the forms and send back as soon as they can.

Our preferred method however is direct referral from the Rooms so that we can take action on any pre-existing problems before admission. These can include and are not limited to:

- Pathology / radiology requirements
- Anaesthetic / Physician referral
- Community service referral
- Discharge planning / Early Rehabilitation referral
- A linking of internal services such as: Infection control, Dietician, HDU ICU referral, physiotherapy and occupational, Alert management and Occupational Health and Safety measures.

Direct referrals can be made by faxing the Pre-admission Referral Form or by directly contacting us on 9411 7358.

Discharge Coordination Services

St Vincents & Mercy has dedicated Discharge Coordinators on each site:

St Vincents Private:
Cath O'Hehir – 9411 7479

Mercy Private:
Jacinta Knox / Jenny Silvers – 9928 6244

Vimy Private:
Melanie Carlyon – 9851 8888

Discharge Coordinators aim to provide a safe a supported discharge for patients.

They keep up to date with Health Fund changes and are able to make appropriate decisions and referrals regarding services are available in the community and are able to navigate through Health Fund eligibility.

Discharge Coordinators manage the Hospital in the Home program as well as arranging Post-acute Care for patients. Post-a cute Care is care that is required for the patient on discharge from hospital but would not necessitate an inpatient stay for the care to continue safely e.g., simple wound care.

Hospital in the Home (HITH) episodes are substitutes for acute inpatient care. This means that if the level of care were not available outside the hospital walls the patient would need to be in hospital to receive ongoing care. Such care may include:

- Parenteral antibiotics
- Drain tube management
- Acute surgical wounds requiring VACC pumps
- Wound care required more than once daily
- Anticoagulant therapy (Clexane or Fragmin).

This is a successful program for which we receive consistently high level patient feedback. Patients enjoy going home knowing that Nursing Staff are at the end of the phone and will come to their home each day to provide care that would normally keep them in hospital.

The Continuum of Care Team thank you for your ongoing support and are here to assist you with bringing your patients in and out of hospital safely. ■

New by-laws

The current by-laws have been in place for over 5 years since they were last reviewed by Mr John Doyle. A lot of changes have occurred in the clinical governance area over that period, not least being the changes brought about by national registration and the recommendations from enquiries into the events in Queensland, New South Wales and Victoria. We engaged Mr Wayne Cahill of Blake Dawsons to review the by-laws and suggest appropriate changes. This process has now been completed and the new by-laws have been approved by the Medical Advisory Committee and the Hospital's Board. They are now in the process of being reviewed by the Hospital's owners, St Vincent's Health Australia and Mercy Health and Aged Care. Assuming they approve the modifications, the new by-laws would then become active. A major change is the removal of the attached Rules and Regulations document that essentially was a repackaging of hospital policies and procedures. The existing requirements for VMP's to notify the Hospital of various events have been strengthened and the activity requirement for continued credentialing has been clarified. A new credentialing category, Emeritus Consultant, has been created to honour retired VMP's that have made a significant contribution to the Hospital.

Change to nurse documentation

Nursing staff will no longer be documenting in the Progress Notes. Instead, they will record variances to expected patient outcomes on the Clinical Pathway Variance/Outcome Record. Medical and Allied Health staff will continue to document on the Progress Notes.

The hospital is in the final stages of implementing this change in line with best practice standards for specific surgical DRGs, with the addition of Generic Medical and Surgical pathways. Variance documentation allows for analysis of variances that can be used to improve practice that is evidence-based.

We look forward to your continuing contribution and support of this change and welcome your ongoing feedback and suggestions to improve practice.

Workplace

Day of Surgery Admissions (DOSA)

St Vincents & Mercy Private are funded principally by a fixed amount per episode based on industry length of stay benchmarks for each Diagnostic Related Group (DRG).

In most cases, days in hospital prior to surgery are not funded by health insurers. Accordingly, higher DOSA rates significantly improve the efficiency of the hospital from both Revenue per Bed Day and bed access aspects. Across all three hospitals our DOSA rate is 75%, however at St Vincents Private it is only 55%. This is well below our peer hospitals. St Vincents Health Melbourne run at 82 % DOSA and another large Melbourne private not for profit hospital claim to run at 90% DOSA rates. We encourage you to access our pre admission service early to help streamline the patient flow and admit patients from metropolitan areas on the actual the day of surgery. For further details about the Pre-admission service, please refer to the article on page 5.

In August, surgeons in the major specialities will receive a report that compares your top 5 DRG's to your peers at STVMPH and to industry benchmarks. We have also included your DOSA data which reflects the % of patients admitted on the actual day of surgery, divided between patients from metropolitan and non metropolitan areas. This report includes a ranking of DOSA of how you compare with your peers who operate at our hospital. There is also a comparison with the Catholic Negotiating Alliance (CNA) benchmark which includes many major catholic acute hospitals in Australia.

It is our philosophy to share relevant information with our key partners to help improve their understanding of health funding and to reduce inefficiencies in the health system. We are also very mindful though that our first priority must be to manage your patients safely and appropriately. The time and resources invested from admission to discharge is always based on clinical need not strict funding guidelines. Also, more efficient use of our beds (i.e. reduced LOS) will ensure improved access for your 'new' patients.

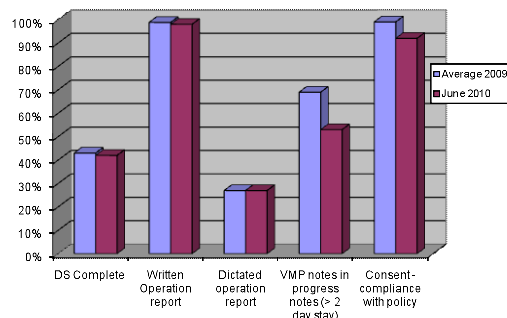
We need to continually review our patient care pathways to ensure that we are striving for 'best' practice and we would appreciate your thoughts on how this can be improved.

Please do not hesitate to contact Ian Grisold on 9928 6813 or the Director of Nursing at each site if you wish to discuss in more detail. ■

How complete are our medical records?

EQuIP Criterion 1.1.8: The health record ensures comprehensive and accurate medical information is recorded and used in care delivery.

As part of our commitment to ongoing improvement and compliance with EQuIP accreditation requirements, we have audited our records to assess the completeness of medical documentation.



Dictated Operation Reports

Our focus over the coming months will be to increase the number of dictated operation reports received within four days of discharge.

GOAL: **Every surgical episode to be recorded in a dictated/typed report**

ACTION: HIS invites any VMPs not currently using our dictation service to contact HIS on 9411 7695 for further information.

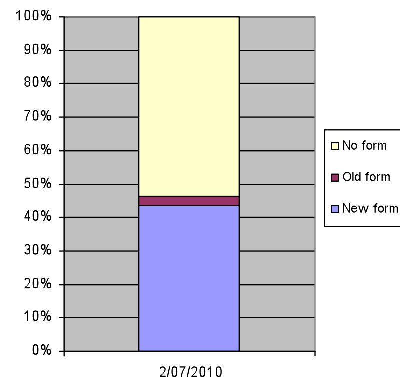
Alternatively, we would be pleased to receive copies of reports generated in your consulting rooms.

Dictated operation reports assist with the ongoing care of patients by providing a clear and concise account of surgery. The added detail helps improve coding accuracy which can potentially increase funding.

Discharge Summaries

Earlier this year, we modified our discharge summary to help ensure we get paid for the work we do.

The graph below shows that currently 43% of patients have a discharge summary completed at the time of coding. We aim to move this result to 70%.



We encourage all VMPs and registrars to complete a discharge summary for all overnight patients at the time of discharge. For all day stay admissions it is more important to receive a dictated operation report within four days of discharge. ■

Clinical Review Committee

News from the Clinical Review Committee

The Clinical Review Committee is a group of VMPs, senior nurses and administrators who meet three monthly to review deaths in the hospital. There has recently been a reshuffle in VMP members with Prof Richard Gerrarty and Mr Brendan O'Brien leaving after a sterling contribution. Dr Valerie Tay, Mr Paul Smith and Mr Michael Dooley have replaced them.

The scope of the committee will increase to consider episodes of serious morbidity as well as the outcome reports from the different craft groups. The committee plays an important role in identifying areas for improvement in clinical practice. It reports to the Medical Advisory Committee.

In coming months you may receive a letter requesting information about a particular case, which has been referred to the committee. This is designed to be a learning exercise to inform continuous improvement and I hope every one will see it as such.

Likewise if a VMP has experiences or observations about practice they feel should be referred for review please feel free to send items for the committee to Georgie Cooke in Bill Kelly's Office. ■

Lockers in the OR

Some things go in waves. I'm getting increasing complaints from VMP's who can't get a locker in the OR change rooms, particularly at Mercy. We are definitely short of lockers and we are looking into getting more but it would appear that lockers are being increasingly "reserved" by people persistently not removing their padlock at the end of their lists. This is selfish and against Hospital policy. Correct procedure is to remove your personal Hospital-supplied padlock at the end of your list and put it on the bar. At some stage in the near future, these "reserved" lockers will be "unreserved" by either having the padlock unlocked or cut.

Workplace

Hand hygiene

Health care associated infections (HCAI) are a major and growing issue in the quality and safety of health care, in both the hospital and the community. Poor hand hygiene practice (hand washing, hand disinfection) among Health Care Workers (HCWs) is strongly associated with nosocomial infection transmission and is a major factor in the spread of antibiotic-resistant pathogens in hospitals.

Hand hygiene contributes significantly to keeping patients safe. It is a simple, low-cost action to prevent the spread of many of the microbes that cause HCAIs. While hand hygiene is not the only measure to counter HCAI, compliance can dramatically enhance patient safety. Improving the hand hygiene of healthcare staff is one of the most effective ways of preventing and reducing the spread of healthcare associated infection.

St Vincents & Mercy Private is participating in the National Hand Hygiene Initiative conducted by Hand Hygiene Australia. You may be familiar with this national approach to improving hand hygiene through other organisations you are associated with. This program is strongly supported by St Vincents & Mercy Private Executive and the Infection Control team.

The basis of this program is to ensure hand hygiene is undertaken by all Health Care Workers according to the "5 moments for Hand Hygiene":

1. **Before Touching a Patient**
2. **Before clean/ aseptic procedures**
3. **After a procedure or body fluid exposure risk**
4. **After touching a patient**
5. **After touching a patient's surroundings.**

The latest guidelines recommend Hand Hygiene after contact with inanimate objects, including medical charts and equipment in the immediate vicinity of the patient- even if you don't touch the patient.

Central to the Hand Hygiene initiative is the use of alcohol-based hand rub (ABHR). This, coupled with changes in the recommended indications for Hand Hygiene and a change in the Hand Hygiene culture of HCWs (attitudes and behaviour), provides the best approach to preventing nosocomial infection transmission. Recent research has demonstrated that ABHRs are better than traditional soap and water because they:

- Require less time to use
- Result in a significantly greater reduction in bacterial numbers than soap and water in many clinical situations
- Cause less irritation to the skin
- Can be made readily accessible.

The alcohol based hand rub is available at every bed/cot area. Staff have been requested to remind all individuals of the need for strict hand hygiene. Please be aware that when you are reviewing your patients you may be asked/ reminded to use the Hand Gel.

There has been a recent focus on Hand Hygiene auditing of all staff at St Vincents & Mercy Private. As with all staff, doctors will be regularly assessed for their rates of compliance. The aim is for a steady, sustainable, month by month, year on year improvement of Hand Hygiene practices. ■

Staggering

St Vincents Day Procedure Unit has commenced staggering admission times for day-of-surgery patients. These include patients for hand surgery, ophthalmology, endoscopy and gynaecology.

Positive affects in the Unit are reduced congestion, improved patient flow to theatre, compliance with best practice, and most important, improved positive feedback from patients.

St Vincents Private would like to thank the current doctors for their participation, and support during this transition in the Unit.

Staff news

Winter Ball

Nearly 600 staff, doctors, partners and others associated with SVMPH attended our Winter Ball on 7 August at Atlantic, Docklands. Guests were greeted with African dance, drumming and fire throwing which set the tone for a night of great entertainment. Aerial artists performed from rigging high above the dance floor and the vibrant style of Bjorn Again ensured everyone was on the dance floor.

Gillian Conley summed up the night well, 'There were smiles on everyone's faces from the beginning to the end. The food was delicious, the venue was exquisite and the entertainment was world class! We had a fantastic time.' ■

Facility update

Mercy Rehabilitation unit

Mercy Rehabilitation opened on the 31 May 2010, catering for our Orthopaedic and Neurosurgery patients post surgery who require intensive inpatient rehabilitation.

The 12 bed unit provides comprehensive rehabilitation under the care of specialist rehabilitation physician Penny Smith and

Nurse Unit Manager Marija Barac, together with a team of nurses and allied health staff.

The unit has cared for 84 patients to mid August with 50% from St Vincents Private and the balance from Mercy and Vimy; in all 34 surgeons have transferred patients to the unit.

The first patient, Kevin Carey was transferred from St Vincents Private after a total knee replacement by Anita Boecksteiner. Kevin found that 'the rehabilitation team helped me to manage my expectations after surgery and set realistic exercise goals to optimise my recovery, the staff were very supportive'.

The aim of the unit is to restore each patient to an optimum level of function enabling them to regain their independence.

Sheryl Ormsby an inpatient in June wrote to thank the team saying: 'To my rehab family, Dr Penny Smith, Marija and the dynamic team. Compassion-

Kevin Carey during a session in the gymnasium.

Accountability-Respect & Excellence spell's "Welcome to Rehab" @ the Mercy.

Therapy facilities include gymnasium, kitchen and hydrotherapy pool.

To refer please contact Marija Barac on 9928 6966. ■

StV Pathology

"Serving the Community for over 100 years"

Your pathology service at St Vincents & Mercy Private